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Alcohol to be included in new substance misuse strategy

John Curran TD, minister of state with responsibility for the drugs strategy, announced on 31 March 2009 that the Government had approved a combined substance misuse policy to include both alcohol and drugs. This proposal was brought to Government by the Department of Community, Rural and Gaeltacht Affairs and the Department of Health and Children.

Making the announcement, Minister Curran said:

A combined strategy will facilitate a more coherent approach to the issues and consequences of alcohol and illicit drug use including addictive behaviours. We cannot continue to look at these problems in isolation.

Questioned about the new strategy in Dáil Éireann on 29 April 2009, the Minister said:

I expect to be presenting the draft strategy to Government for consideration in late May or early June. The measure, as approved by Government, will be published as an interim strategy pending the drafting and finalisation of a national substance misuse strategy. In this context, the Deputies should note that a new steering group will be established in the autumn to develop proposals for the overall substance misuse strategy, which will incorporate the already agreed drugs policy element. The group will be asked to report by the end of 2010.¹

1. Curran J (2009, 29 April) *Parliamentary Debates Dáil Éireann (Official Report – Unrevised)*, Vol. 681, No. 2: 362.

Dublin hosts 2009 European Health Libraries workshop



Attending the launch of the EAHIL 2009 Workshop in Dublin Castle were (l to r): Enda Connolly, CEO Health Research Board; Louise Farragher (National Documentation Centre on Drug Use), Chair of the organising committee; Mary Harney TD, Minister for Health and Children; Suzanne Bakker, President of EAHIL; and Paul Murphy, Chair of the programme committee. (Photo: Richard Stokes)

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- Sedative, tranquilliser and anti-depressant use in Ireland
- Inclusion Programme for young people evaluated
- Fourth ESPAD survey results
- Report examines effects of decriminalisation in Portugal
- Guidelines on 'quasi-compulsory' treatment
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EAHIL Workshop 2009 (continued)

The European Association for Health Information and Libraries 2009 biennial workshop was held in Dublin Castle on 2–5 June. The workshop was hosted by the Health Science Libraries Group of the Library Association of Ireland and by the Health Research Board. Louise Farragher of the National Documentation Centre on Drug Use chaired the committee which organised the event, the largest of its kind to be held in Ireland.

Opened by Mary Harney TD, Minister for Health and Children, the workshop was attended by over 230 delegates from Europe, North America and South Africa. The programme comprised seven continuing education courses, eight empowerment workshops, six plenary papers, 30 posters and 38 paper presentations, all based on the theme 'Working with Others.'

In her opening address Ms Harney acknowledged the important role of information professionals in the conversion of information into the knowledge which is needed to

inform decision making in the health system. Information scientists and librarians must present evidence in a clear and understandable way and deliver it to the right people at the right time, through guidelines, protocols and other information supports. Minister Harney emphasised the importance of ensuring that evidence-based decision making is understood at all levels, including the political level. Information professionals have a role to play in informing public opinion and winning support for change. Unlike lobbyists and interest groups, their interest is in providing the most relevant information and they should be prepared to knock on the doors of health ministries and other policy makers to ensure that this is information is available where it is needed. Paul Murphy, chair of the workshop's programme committee, thanked the staff of the 18 Irish healthcare and educational institutions who were involved in the organisation of the workshop.

International conference on drug policy

The third annual conference of the International Society for the Study of Drug Policy (ISSDP) was held in Vienna between 2 and 4 March 2009. Scholars, analysts and researchers from around the world met to hear some 50 papers on the following themes:

- Cannabis, including production, markets and policy
- Politics, values and science in drug policy formation
- Policy analytic frameworks including harm reduction
- Policy assessment including cross-national comparisons
- Public expenditure on the drugs issue and the cost of drug use
- Statistical modelling and microsimulation

On the third day there were two half-day workshops on compiling a drug-harm index and on modelling.

The variety of the conference programme is illustrated by the following quotations taken from the presentations of a selection of contributors:

- Law enforcement agencies can make a substantial contribution to reducing drug-related harms, for example by seeking to eliminate 'noxious' dealing,

which is defined as including additional elements such as violence, corruption, terror or environmental damage. While such action may not reduce the size of the drug market, it will reduce the amount of collateral damage. Similarly, ensuring that children and other dependants of those arrested for drug-related offences are not exposed to dangers or risks as a consequence of the arrest will also help to contain the extent of the harm inflicted.
(Jonathan Caulkins, USA)

- There are at least two important and ignored topics in the literature on the social cost of illegal drugs. First, social cost ignores human suffering associated with drugs. Second, it does not focus on friends and family of the drug user. These failures result in an under-estimation of the overall size of the cost of drug use and, in turn, lead to an under-prioritisation of the issue of human suffering.
(Hans Olav Melburg, Norway)
- If states do decide to make cannabis legally available, it is recommended that a system of strict government-controlled regulation be employed, with controls on price, quality, potency and availability along with good public education about

International conference on drug policy (continued)

the harms of cannabis use and bans or restrictions on advertising and promotion. The effects of any changes need to be closely monitored and inform prompt revision of the changes if indicated.
(Peter Reuter, USA)

- A study of how Australian policy-makers obtain advice on policy development shows that research evidence is but one bit-player in the overall decision-making process. This finding suggests that 'evidence-informed' policy may be a more accurate description of the way that research findings influence policy than the more usual term 'evidence-based' policy.
(Alison Ritter, Australia)
- Benefits are to be gained from combining research into illicit drugs, alcohol and tobacco.
(Robin Room, Australia)
- The drugs problem is a complex constellation of issues and difficulties associated with the production,

distribution and consumption of illegal drugs. Viewing it as a governance problem may open up more effective ways of tackling the various dimensions, drawing on a number of different social science perspectives on governance to develop new and integrated approaches.
(Toby Seddon, UK)

- Diversified oral substitution is not able to eradicate risk behaviours or to attract those morphine users who are not able or not willing to stop injecting. For those users, programmes offering injectable preparations of substances for substitution seem to constitute the more adequate option.
(Alfred Springer, Austria)

Further information on the conference, and on the two preceding annual conferences, is available on the website of the ISSDP www.issdp.org.

(Brigid Pike)

International context for Ireland's new drugs strategy

Since 2001 Ireland's drugs strategy has been formulated within the context of the policy frameworks on illicit drugs adopted by the UN and the EU. While broadly similar in approach, there are differences in emphasis between the UN and EU frameworks which leave room for member states, such as Ireland, to exercise some discretion in developing national policy priorities. Some features of the current international illicit drug policy frameworks of relevance to Ireland's drugs strategy are noted here.¹

In their illicit drugs strategies both the UN and the EU reaffirm the primacy of the three international drug control conventions as the basis for drug policy, acknowledge the rule of law and undertake to uphold respect for concepts such as human dignity, liberty, democracy, equality, solidarity, and human rights. In setting out their high-level aspirations with regard to illicit drugs, however, the two entities diverge.

- The UN's ultimate goal is 'to minimize and eventually eliminate the availability and use of illicit drugs and psychotropic substances in order to ensure the health and welfare of humankind', to which end it encourages 'the exchange of best practices in demand and supply reduction', and emphasises that 'each strategy is ineffective in the absence of the other'.
- The EU has two aims: to contribute to 'the attainment of a high level of health protection, well-being and social cohesion by complementing the Member States' action in preventing and reducing drug use, dependence and drug-related harms to health and society' and to ensure 'a high level of security for the general public by taking action against drugs production, cross-border trafficking in drugs and diversion of precursors, and by intensifying preventive action against drug-related crime, through effective cooperation embedded in a joint approach'.

In other words, unlike the UN, the EU stops just short of seeking a drug-free world.

Both international frameworks emphasise the need for an integrated, multidisciplinary, mutually reinforcing and balanced approach to supply and demand reduction strategies. At this point, however, the two bodies diverge: the EU uses the term 'harm reduction' but the UN prefers a vaguer term, 'related support services'. To elaborate:

- The EU calls for the development and improvement of 'an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and social reintegration measures within the EU member states'. It further states that drug demand reduction measures must take into account the health-related and social problems caused by the use of illegal psychoactive substances and of polydrug use in association with legal psychoactive substances such as tobacco, alcohol and medicines. Furthermore, it calls for the different levels of health risks involved with different forms of drug use (such as polydrug use) or life periods and specific situations (such as early adolescence, pregnancy, driving under the influence of drugs) to be taken into account in developing demand reduction interventions.
- The UN affirms its commitment to 'effective, comprehensive, integrated drug demand reduction programmes, based on scientific evidence and covering a range of measures, including primary prevention, early intervention, treatment, care, rehabilitation, social reintegration and related support services'. It states that demand reduction strategies should be aimed at promoting health and social well-being among individuals, families and communities and reducing the

International context *(continued)*

adverse consequences of drug abuse for individuals and society as a whole, taking into account the particular challenges posed by high-risk drug users, in full compliance with the three international drug control conventions and in accordance with national legislation. It also states that member states should ensure access to demand reduction interventions on a non-discriminatory basis, in detention facilities as elsewhere, bearing in mind that those interventions should also consider vulnerabilities that undermine human development, such as poverty and social marginalisation.

Both international bodies acknowledge the need for evidence-based policy. The UN calls for member states to develop and use 'indicators and instruments for the collection and analysis of accurate, reliable and comparable data'. The EU's overall objective in relation to information, research and evaluation suggests that the EU drug research community is at a more advanced stage of development than the UN equivalent: the EU strategy calls for 'a better understanding of the drugs problem and the development of an optimal response to it through a measurable and sustainable improvement in the knowledge base and knowledge infrastructure'.

Drugs policy researcher Professor Peter Reuter argues that over the past 10 years policy makers around the world

have tended to ignore the growing body of evidence showing that drug use prevalence has been insensitive to policy interventions.² According to Reuter, no prevention, treatment or enforcement strategies have demonstrated an ability to substantially affect the extent of drug use and addiction. He calls on the drugs policy community to be open to reviewing all the evidence and exploring new policy options: '... discussion of policy should pay more attention to how few of the intended effects are achieved by most policies and how many and troubling are the unintended effects, particularly of tough enforcement' (p. 515).

(Brigid Pike)

1. This account is based on a reading of two documents: the EU Drugs Strategy 2005–2012 (CORDROGUE 77), retrieved on 24 March 2009 from www.emcdda.europa.eu and the UN Draft Political Declaration (E/CN.7/2009/L.2), retrieved on 24 March 2009 from www.unodc.org. The latter document, together with a 10-year action plan, was agreed at the High-Level Segment of the 52nd Session of the Commission on Narcotic Drugs (CND), which met in Vienna in March 2009.
2. Reuter P (2009) Ten years after the United Nations General Assembly Special Session (UNGASS): assessing drug problems, policies and reform proposals. *Addiction*, (104): 510–517.

Is the 'fight against drug abuse' at EU level adding value?

Within the EU, Irish citizens are among those most concerned about the drugs issue and most supportive of EU-level action in relation to drugs. However, Irish citizens are also among those who do not see the added value of the actions being taken at EU-level compared to those being taken at national level. They are also among those not entirely satisfied with the EU's communications regarding its fight against drugs.

These findings were reported in a Flash Eurobarometer report on a survey of awareness among EU citizens of key policies in the Freedom, Security and Justice area, published in January 2009.¹ The aim of the survey was to examine the level of concern that EU citizens feel about policies in the Freedom, Security and Justice area, the amount of support for EU-level actions in that area, and citizens' opinions as to whether the EU should be communicating its policies more efficiently.

Level of concern

The survey results showed that a majority of respondents feel concerned about each of the nine policy areas covered in the survey. Primarily, the interviewees are concerned about the fight against organised crime and terrorism and against drug abuse (both 80%). Concern about the fight against drug abuse is highest in southern European countries – Cyprus, Portugal, Malta, Greece and Spain (between 91% and 95%). In Ireland nine out of 10 citizens say they are concerned about the drugs issue.

Support for EU-level action

EU citizens largely feel that EU-level actions add the most value in the fight against organised crime and terrorism (72%), and then in the fight against drug abuse and the promotion and protection of fundamental rights, including children's rights (both 65%). Contrary to this overall pattern, citizens of Luxembourg and Portugal believe that the fight against drug abuse benefits more than the fight against organised crime and terrorism from actions taken at EU-level compared to those at national level (both 76%; 11 percentage points above the EU average). They are followed by citizens from Spain (74%), Sweden and Belgium (73%), and Ireland (72%).

Citizens' level of concern and support for EU-level action

Ireland is among the top five countries whose citizens combine concern about the issue and support EU-level action in the fight against organised crime and terrorism (71%), in the fight against drug abuse (67%), and in the protection of fundamental rights (71%). At the same time, 19% of Irish citizens say they are concerned about the fight against drug abuse but do not see value being added by actions being taken at EU-level compared to the national level alone.

Views on efficiency of communication of policies to EU citizens

Overall, three-quarters of respondents think the EU should improve its dissemination of information on its policies and

Flash Eurobarometer (continued)

actions with regard to the fight against organised crime and terrorism (78%), the fight against drug abuse (76%) and the promotion and protection of fundamental rights, including children's rights (75%). The highest proportions of citizens not completely satisfied with the EU's communication in the area of the fight against drug abuse are to be found in Greece, Ireland and Portugal, with 88%, 86% and 85% of respondents, respectively, seeing the need for better communication.

(Brigid Pike)

1. Gallup Organization (2009) *Flash Eurobarometer 252: Awareness of key-policies in the area of Freedom, Security and Justice*. Brussels: European Commission. Retrieved on 9 April 2009 at www.ec.europa.eu/public_opinion. The fieldwork was carried out between 5 and 9 September 2008. Over 27,000 randomly selected citizens aged 15 years and over were interviewed in the 27 EU member states. Approximately 1,000 interviews were carried out in each country, predominantly via fixed telephone lines

using WebCATI (web-based computer assisted telephone interviewing). To correct for sampling disparities, a post-stratification weighting of the results was implemented, based on important socio-demographic variables. Details on the survey methodology are included in the Annex of the report. The policies surveyed included immigration policy, asylum policy, the exchange of police and judicial information between member states, the fight against organised crime and terrorism, the fight against drugs abuse, the control of the EU's external borders, the promotion and protection of fundamental rights, including children's rights, and the improvement of access to justice.

LDTFs look to 2009 and beyond

In 2007/08 local drugs task forces (LDTFs) completed a strategic review and planning process, undertaken at the invitation of the National Drugs Strategy Team (NDST). The object of the exercise was to identify the needs in LDTF areas in relation to drug misuse, to contribute to the 'renewal' of LDTFs by enabling the sharing among all agencies and sectors of a clear strategic focus, and to help inform the choice of future drug strategies. This article summarises the findings of an unpublished analysis of the reports furnished to the NDST by the 13 LDTFs.¹

Community profiles

The LDTFs identified a number of common themes indicating continuing social deprivation in their areas, including lower levels of educational attainment and higher levels of unemployment, local authority housing and lone parent households than the national average. They also outlined how local settlement patterns may be affecting their work. LDTF catchment areas may contain neighbourhoods experiencing deprivation interspersed with neighbourhoods experiencing 'significant advantage': this presents challenges for targeting services effectively. Certain LDTFs have seen the 'gentrification' of their areas: this has led to heightened feelings of isolation and marginalisation among some of the original residents.

Nature and extent of drug use

The LDTFs reported that heroin is still the primary drug of misuse. However, there has been a significant increase in the use of cocaine, alcohol and prescription drugs. In line with this expansion, the incidence of polydrug use has also increased. With regard to users, the LDTFs highlighted the much higher drug-use prevalence among males than females. They drew attention to the increased drug use among non-Irish and Traveller communities, and among the homeless. They also noted the increased prevalence of blood-borne viral infections and the relationship between drug misuse and mental health. These patterns of drug use raise challenging issues with regard to the design and delivery of effective drug-related services.

Gaps in services

A range of gaps in service provision was highlighted by the LDTFs, including:

- services that are accessible to non-national communities,
- childcare services for clients wanting to attend treatment and rehabilitation services,
- drug services catering exclusively for the needs of young drug users,
- prevention initiatives for people in the early stages of drug use,
- services for people misusing alcohol, and
- supply reduction initiatives at local level.

Strategic priorities

The role of the LDTFs is to prepare action plans that will ensure the implementation of the national drugs strategy at local level. The LDTFs identified strategic priorities under the pillars of the strategy, including the following:

- Research: develop a comprehensive monitoring and evaluation system to measure the effectiveness of drug projects, and encourage projects piloting new programmes to evaluate them on a regular basis, and conduct locally based research projects.
- Prevention: refocus prevention work to take into account peer processes, family support and community development, e.g. increase early intervention programmes in pre-school and early primary school years, with a special focus on children of drug users and children of families in difficult circumstances.
- Treatment and rehabilitation: adopt the continuum of care approach to meeting the needs of clients, and develop an appropriate range of treatment and rehabilitation services for young people (aged 12–18 years), e.g. develop a separate strategy for under-18s,

LDTFs look to 2009 and beyond (*continued*)

or pilot psychosocial support projects for under-18s in collaboration with the HSE.

- Supply reduction: support existing anonymous 'dial to stop drug dealing' type initiatives and establish similar schemes in LDTF areas where they currently do not exist; hold community information evenings to exchange information, network and build and develop partnerships between the gardaí, the community and drug-related services.
- Family support and co-ordination: establish training in strengthening families for all workers, and put in place early intervention initiatives to build capacity within families; develop policies and procedures to improve communication across the various groups and projects active within the LDTF areas.

Effectiveness of LDTF structures

LDTFs were generally positive about their role in introducing and supporting drug-related services and initiatives and were also confident that their structures and processes were functioning effectively. The management of mainstreamed

projects, and the ongoing role and responsibility of LDTFs with regard to these projects, was raised as an issue. In parallel, some LDTFs highlighted the limited input and in some cases lack of interest on the part of statutory services regarding the task force process, and lack of clarity about their own roles on the LDTFs. Strategic priorities included:

- increasing the profile and understanding of the work of the LDTFs in the community through the development of comprehensive communication strategies,
- facilitating the involvement of people affected by drug addiction in the work of the task forces by supporting the establishment of service-user forums, and
- developing key performance indicators and systems to monitor progress and inform future development across programmes.

(Brigid Pike)

1. Foran S (2008) *Local drug task force strategic review and planning process 2008–2013: An overview*. Report prepared for the NDST. Not published.

Ban on stimulant drug, BZP

On 31 March 2009, Minister for Health and Children, Mary Harney TD, announced that 1-benzylpiperazine (BZP) is now a controlled drug under statutory instruments (121 and 122 of 2009) amending the Misuse of Drugs Act 1977, and that its possession or sale is now a criminal offence. The new statutory instruments will ensure that BZP is no longer available for sale in 'head shops' around the country or on the streets.

BZP is a relatively new synthetic psychotropic (mood altering) substance which has been sold as ecstasy under the street names 'Legal E', 'Legal X' 'XTC', 'A2', 'piperazine', or 'party pills'. In Ireland, party pills containing BZP have been widely sold in head shops.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) conducted a risk assessment of BZP

in 2007 and found that its use can lead to various medical problems, though the long-term effects of the substance are still unknown. The risk assessment report concluded that due to its stimulant properties, risk to health and the lack of medical benefits there was a need to control BZP. Against this background, the Council of the European Union decided in July 2007 that BZP should be defined as a new psychoactive substance which was to be made subject to control measures and criminal provisions.¹

(Jean Long)

1. See Long J (2007) BZP - information exchange, risk assessment and control measures. *Drugnet Ireland*, (23): 21.

Directory of community drugs projects

CityWide Drugs Crisis Campaign has compiled a directory of community-based drugs projects in Dublin and Wicklow.¹ The purpose of the directory is to facilitate the development of formal links between prison and community services by providing up-to-date information on community projects, their services, locations and contact details.

The directory is an initiative of a Dublin Prison Liaison Group which includes members of the Irish Prison Service, prison staff and representatives from community-based projects. The Liaison Group has been operating since 2000 in an

effort to improve throughcare between prison services and community services for drug users.

The directory can be accessed on the CityWide website at www.citywide.ie

(Anne Marie Donovan)

1. CityWide (2009) *Directory of community drugs projects: working with individuals within Irish prisons and post release services*. Dublin: CityWide.

Launch of Dublin 12 Local Drugs Task Force strategic plan

The Minister of State with responsibility for drugs strategy, John Curran TD, launched the Dublin 12 Local Drugs Task Force strategic plan 2009–2013 on 12 May 2009 at the Red Cow Moran Hotel. The launch was followed by workshops on a number of themes, including the availability of treatment, rehabilitation, education and prevention initiatives, and families dealing with drug issues. The plan is the product of extensive consultation with stakeholders in the catchment areas of Crumlin, Drimnagh, Kimmage and Walkinstown. Specific aims and objectives in the new strategy include:

Treatment – continue to develop the Cross Task Force harm reduction/needle exchange service and increase collaboration between drug treatment and alcohol services.

Rehabilitation – lobby for a rehabilitation/integration service (RIS) and increased rehabilitation options, and develop forums and networks such as the D12 Service Users Forum.

Education – consolidate and develop interventions aimed at young people at risk, develop links with schools and provide accredited addiction studies courses locally.

Supply control – work towards implementing initiatives such as the Joint Policing Committees and the Dial to Stop Drug Dealing campaign, and develop the Community Safety Partnership with the gardaí and other community stakeholders.

Research – strengthen data, collection systems, commission local research to inform service planning, and participate in national-level studies.



Caroline Kavanagh, chairperson of D12LDTF, with Minister John Curran at the launch of the strategic plan (Photo: Tara O'Reilly)

Family support – re-establish family support groups and support the development of child care facilities for drug-using families.

Alcohol – develop a plan to address alcohol misuse, identify local alcohol services and form stronger relationships with them.

(Anne Marie Donovan)

1. Dublin 12 Local Drugs Task Force (2009) *Strengthening our collective responses: strategic plan 2009–2013*. Dublin: Dublin 12 LDTF. Available online from the National Documentation Centre library at www.hrb.ie/ndc

Sedative, tranquilliser and anti-depressant use in Ireland

The sixth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey focuses on sedative or tranquilliser and anti-depressant use in the adult population (15–64 years).¹ The final achieved sample was 4,967 in Ireland. This represented a response rate of 65%.

This article highlights some of the survey findings and presents unpublished data from the National Drug Treatment Reporting System (NDTRS) and the National Drug-Related Deaths Index (NDRDI).

Use by adult population in 2006/7

The proportion of **adults** who reported using a sedative or

tranquilliser² at some point in their lives was almost 11% (Table 1a). The proportion of **young adults** was 6%, while the proportion of **older adults** was higher at just under 15%. More women (13%) than men (8%) reported using a sedative or tranquilliser in their lifetime.

The proportion of **adults** who reported using a sedative or tranquilliser in the last year was almost 5%, and of **older adults** almost 7% (Table 1a).

The proportion of **adults** who reported using a sedative or tranquilliser in the last month was 3%, and of **older adults** just over 4% (Table 1a).

Table 1a Prevalence of sedative and tranquilliser use in Ireland, 2006/7

	Adults 15–64 years (%)	Males 15–64 years (%)	Females 15–64 years (%)	Young adults 15–34 years (%)	Older adults 35–64 years (%)
Lifetime (ever used)	10.5	8.0	13.2	5.9	14.6
Last year (recent use)	4.7	3.7	5.7	2.5	6.5
Last month (current use)	3.0	2.4	3.5	1.3	4.4

Source: NACD and DAIRU (Bulletin 6, 2009)

Sedative and anti-depressant use in Ireland (continued)

The proportion of **adults** who reported using an anti-depressant³ at some point in their lives was just over 9% (Table 1b). The proportion of **young adults** was 7% while the proportion of **older adults** was higher at just under 11%. More women (13%) than men (6%) reported using an anti-depressant in their lifetime.

The proportion of **adults** who reported using an anti-depressant in the last year was just over 4%, and of **older adults** just over 5% (Table 1b).

The proportion of **adults** who reported using an anti-depressant in the last month was just over 3%, and of **older adults** just under 4% (Table 1b).

Table 1b Prevalence of anti-depressant use in Ireland, 2006/7

	Adults 15–64 years (%)	Males 15–64 years (%)	Females 15–64 years (%)	Young adults 15–34 years (%)	Older adults 35–64 years (%)
Lifetime (ever used)	9.2	5.9	12.5	7.1	10.9
Last year (recent use)	4.3	3.0	5.6	3.2	5.2
Last month (current use)	3.1	2.3	3.9	2.2	3.9

Source: NACD and DAIRU (Bulletin 6, 2009)

Practices among users – 2006/7 survey

Those who had ever used: The average age at first use of sedatives or tranquillisers was 29 years for males and 31 for females. The average age at first use of anti-depressants was 34 years for males and 30 years for females.

Current users: More than half (57%) of current users of sedatives or tranquillisers, and 91% of current users of anti-depressants, took them daily or almost daily. Most current users got their sedatives or tranquillisers (89%) or anti-depressants (100%) on prescription. However, 11% of sedative or tranquilliser users reported that they had either got them from a friend or another source or bought them without a prescription in a pharmacy.

Sedative or tranquilliser and anti-depressant use was more likely among those who were dependent on the state long-term, were not in paid employment, had lower levels of educational attainment and had left education before the age of 15 years.

Respondents who were separated, divorced or widowed reported higher prevalence rates of sedative or tranquilliser and anti-depressant use compared to those who were single (never married), co-habiting or married.

Use by 15–16-year-old school children – 2007 ESPAD survey

One in ten of the 2007 ESPAD survey participants reported that they had taken prescribed sedatives or tranquillisers at some point in their young lives, and 3% had taken non-prescribed sedatives or tranquillisers.⁴

NDTRS data – sedatives or tranquillisers

According to NDTRS data for the years 2001 to 2007, the annual number of treated cases reporting sedatives or tranquillisers as a main problem drug ranged between 78 and 171 (Table 2). The total for the period was 778 cases, of whom 87% reported a benzodiazepine as their main problem drug. Of the 778 cases, 76% used one or more additional drugs.

Of the 171 cases treated in 2007 who reported sedatives or tranquillisers as their main problem drug, 98% ate them and 0.5% injected them. Use by these cases in the month prior to treatment was reported as follows: 66% used them daily, 12% used them between two and six days per week, 5% used them once per week or less and 11% had not used them. Half had commenced use before they were 19 years old; 66% were men; and 61% lived in Dublin.

Table 2 Cases entering treatment for sedatives or tranquillisers as a main problem drug, 2001 to 2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases	4797	4948	5054	4506	4877	5191	5684
Cases reporting sedatives or tranquillisers as main problem drug	115 (2.4)	104 (2.1)	97 (1.9)	108 (2.4)	78 (1.6)	105 (2.0)	171 (3.0)
Of whom:							
New cases	55	39	37	50	44	55	91
Previously treated cases	52	60	60	52	31	44	74
Treatment status not known	8	5	0	6	3	6	6

Source: Unpublished data from the NDTRS

Sedative and anti-depressant use in Ireland (continued)

Table 3 Cases entering treatment who reported sedatives or tranquillisers as an additional problem drug, 2001 to 2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases reporting an additional problem drug	3459	3582	3760	3157	3401	3692	3816
Cases reporting sedatives or tranquillisers as an additional problem drug	1107 (32.0)	1155 (32.2)	1050 (28.3)	1009 (32.0)	1110 (32.6)	1200 (32.5)	1155 (30.3)
Of whom:							
New cases	252	264	214	176	206	269	273
Previously treated cases	786	826	791	685	747	771	681
Treatment status not known	32	43	26	31	26	21	14
Source: Unpublished data from the NDTRS							

The number of cases reporting sedatives or tranquillisers as an additional problem drug exceeded 1,000 per year between 2001 and 2007 (Table 3). The main drugs associated with sedative or tranquilliser use by new cases entering treatment were cannabis, alcohol, stimulants, cocaine and opiates (Table 4).

NDTRS data – anti-depressants

According to NDTRS data for the years 2001 to 2007, only 10 treated cases reported anti-depressants as a main problem drug, of whom half used one or more additional drugs. In the seven-year period, 56 cases reported anti-depressants as an additional problem drug. The drugs associated with anti-depressant use were opiates and sedatives. Of the 66 cases treated who reported anti-depressants as a problem drug, 53% were men, and 58% lived in Dublin.

Table 4 Main problem drug and associated additional drugs used by new cases entering treatment, 2001–2007

New cases	5741	1526	981	371	14	184	5693
	Main problem drug						
	Opiates	Cocaine	Stimulants	Sedatives/ tranquillisers	Hallucinogens	Volatile inhalants	Cannabis
Additional problem drug(s) used*	Number						
Opiates	848†	102	26	52	2	4	151
Cocaine	1278	14†	272	59	3	3	1056
Stimulants	606	669	257†	62	9	14	2655
Sedatives/ tranquillisers	1267	110	39	27†	0	2	251
Hallucinogens	47	25	37	1	1†	1	165
Volatile inhalants	19	7	16	5	0	9†	127
Alcohol	2209	847	605	109	9	53	10
Cannabis	652	706	422	171	4	62	2719†

* By cases reporting use of one, two or three additional drugs.

† Additional problem drug(s) used may be a form of drug in the same family as the main problem drug.

Source: Unpublished data from the NDTRS

NDRDI data

The NDRDI reported that there were 1,553 deaths as a result of poisoning between 1998 and 2005. The coroners reported that in 703 (45%) of these deaths sedatives, tranquillisers, and/or anti-depressants were implicated

(either alone or in conjunction with other substances) (Table 5). Of those who died, 61% were male, 63% were aged between 20 and 44 years, and 44% were unemployed. Benzodiazepines were the most common form of sedative or tranquilliser implicated in these deaths. Only 113 (16.1%) of the 703 poisoning deaths were attributable to

Sedative and anti-depressant use in Ireland (continued)

a sedative, tranquilliser or antidepressant alone. Of the 590 polysubstance deaths, over half (57.6%) also involved an opiate (often heroin or methadone) and 206 (34.9%) also

involved alcohol. The number of deaths in which anti-depressants played a part increased during the reporting period.

Table 5 Number of poisoning deaths in which sedatives or tranquillisers, and/or anti-depressants were implicated, NDRDI 1998–2005

	1998	1999	2000	2001	2002	2003	2004	2005
All poisoning deaths	178	187	182	175	210	184	205	232
Sedatives or tranquillisers*	88	77	79	57	79	72	87	78
Anti-depressants*	32	34	41	39	47	44	51	49

* Cases involving both sedatives or tranquillisers and anti-depressants are included in the figures for each type of substance.

Source: Unpublished data from the NDRDI

Conclusions

The use of sedatives or tranquillisers by teenagers and adults is common in Ireland, and such use leads to dependence and fatalities. Benzodiazepines are the main type of sedative or tranquilliser used. In order to reduce the negative consequences of benzodiazepine misuse, the Department of Health and Children recommendations need to be revisited.⁵ These included: improvement of the legislation, tighter monitoring and control of prescribing, improved clinical guidelines with an emphasis on short-term treatment and the use of alternative therapies.

(Jean Long and Suzi Lyons)

1. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2009) *Drug use in Ireland and Northern Ireland. 2006/2007 drug prevalence survey: sedatives or tranquillisers, and anti-depressants use results*. Bulletin 6. Dublin: National Advisory Committee on Drugs.
2. 'Sedatives' and 'tranquillisers' are commonly used terms for the same group of medicines which depress, slow down or calm the brain and central nervous system.
3. They are mainly benzodiazepines, but other drugs with the same effects, such as Zolpidem and Zopiclone, are included in this group. Medically they are often referred to as hypnotics, which induce sleep, and anxiolytics, which reduce anxiety. The same drug can be used as a hypnotic or as an anti-anxiety agent depending on the dose used and on the time of day that they are taken.
4. Hibell B *et al.* (2009) *The 2007 ESPAD report: substance use among students in 35 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe.
5. The Benzodiazepine Committee (2002) *Report of the Benzodiazepine Committee*. Dublin: Department of Health and Children.

Use of minor tranquillisers and sedatives in the WRDTF area

The first in a series of three reports commissioned by the Western Region Drugs Task Force (WRDTF), this study¹ analysed treatment and prescription data relating to the use of minor tranquillisers and sedatives² in the west of Ireland, and interviewed addiction service providers and a number of people recovering from addiction to these drugs.

The early section of the report provides the legislative and regulative background to current prescribing practices. Department of Health and Children guidelines³ define correct usage and good prescribing practice. A short literature review looks at the evidence of incorrect use of tranquillisers and sedatives internationally and the harmful consequences of this, including higher levels of risk-taking, fatal overdoses, and poorer health and psychological functioning.

Treatment and prescribing data

The study analysed data from the Health Research Board (HRB) National Drug Treatment Reporting System (NDTRS). These showed that of the 973 cases who entered treatment between 2001 and 2006, 114 (11.7%) reported problem benzodiazepine use. Only nine cases (less than 1%) reported benzodiazepines as a main problem drug. The vast majority of cases entering treatment for benzodiazepine use reported at least one other problem drug. The report points out that those presenting to a GP with an addiction to minor tranquillisers or sedatives are more likely to be referred for treatment to the HSE Mental Health Services than to the HSE Addiction Services. As the HSE Mental Health Services have only recently begun submitting treatment data to the NDTRS, there are probably a number of cases being treated who are not included in the treatment data analysed in this report.⁴

WRDTF area – tranquillisers and sedatives *(continued)*

The study also looked at prescription records held by the HSE Primary Care Reimbursement Service (PCRS). Analysis of these data showed that 89,721 individuals were prescribed minor tranquillisers and sedatives between 2000 and 2007. Almost 88% of prescriptions dealt with by the reimbursement service were for medical card holders. The number of people being prescribed these drugs rose from just below 25,000 to just over 33,000 during this period. These data would suggest that the 2002 prescribing guidelines have had little impact on prescribing practice in this region.

Focus group and health personnel interviews

The author arranged a focus group with six clients of an addiction treatment centre, five of whom had been addicted to a minor tranquilliser or sedative, and one to codeine. Alcohol was the main problem drug in all cases. The focus group revealed that none of the five clients was aware of the risks of dependence on drugs when they were prescribed minor tranquillisers. It was also clear that it was easy to get a prescription and easy to have it repeated. None of the participants in the focus group had been offered alternative therapies.

The author interviewed six addiction counsellors in HSE West Mental Health and 10 substance misuse counsellors in HSE West Drug Service. Both of these groups of service providers expressed broadly similar concerns. The issues raised were:

- Inappropriate prescribing: Many people have become dependent on minor tranquillisers and sedatives as a result of being maintained on them long after the optimum therapeutic period.
- Individual choices in misuse: People prescribed these drugs may not fully understand their addictive potential or the consequences of taking them incorrectly. In cases of alcohol and minor tranquilliser co-dependency, the emphasis in treatment is invariably on alcohol and it is difficult to deal with the addiction to the prescribed drug. Sharing of prescriptions among family members is also an issue.
- Public policy and remuneration issues: Health authorities and professional regulatory bodies have failed to take action to deal with the problem use of these drugs. Payment of professional fees from reimbursement schemes is not conditional on appropriate prescribing or dispensing.

- Diversion and leakage: As a result of over-prescribing of minor tranquillisers and sedatives, a large amount of these drugs become available for illicit use and this drives a thriving black market.
- Key service issues: The counsellors agreed that only a very small proportion of those who have an addiction actually present for treatment. The treatment figures do not provide a true picture of the problem.

The study concludes that there is excessive and inappropriate prescribing of minor tranquillisers and sedatives in the western region. Despite the introduction of good practice guidelines in 2002, spending on these drugs by the public health service doubled between 2000 and 2007. The author points to the failure of this service to control three drivers of incorrect use: pricing, prescribing and distribution. There is limited control of distribution and prescribed drugs are easily diverted to the black market. There is very limited non-medical support to addicts and very little co-ordination between primary care, mental health and community service providers, making it more difficult to identify and deal with problem drug use.

The report makes a number of recommendations, including more rigorous regulation and tighter controls on distribution. Doctors and pharmacists need to be educated on the consequences of over-prescribing and on addiction-related issues, and individuals need to be provided with better information to enable them to make informed decisions regarding their use of these drugs.

(Brian Galvin)

1. Flynn K (2009) *Minor tranquillisers & sedatives: use and misuse in the west of Ireland*. Galway: Western Region Drugs Task Force.
2. Minor tranquillisers and sedatives is the term used throughout the report to refer to a class of psychoactive substances that includes benzodiazepines and related drugs.
3. Department of Health and Children (2002) *Benzodiazepines: good practice guidelines for clinicians*. Dublin: Department of Health and Children.
4. The appointment of a GP and pharmacy liaison nurse in the region has resulted in a substantial increase in the number of cases reported to the NDTRS since 2006.

Substance use in the Traveller community in the WRDTF area

The Western Region Drugs Task Force (WRDTF) has published a report on the nature and extent of substance use, and use of services, by members of the Traveller community in the west of Ireland.¹ This is the second in a series of three reports on substance use in the region commissioned by the WRDTF.

Data were collected from 57 focus groups that included both adult and younger members of the Traveller community. Interviews and consultations were held with

45 service providers, including services dealing specifically with substance use among Travellers. The fieldwork was complemented by prior consultation with stakeholders, desktop research and a literature review.

Service providers reported a marked increase in problematic drug and alcohol use among Travellers in the last 10 years in the west of Ireland. Substance use was mainly seen as an escape from depression, poor health, difficulties with employment and strained relationships with the settled

WRDTF area – Traveller community (*continued*)

community. In terms of risk, older Travellers reported a fear of drugs and potential overdose, with younger Travellers indicating an acceptance of the use of drugs such as cannabis and ecstasy as relatively normal.

Alcohol

According to service providers, alcohol remains the substance of most concern in this community, and increasing levels of use were reported among Traveller men and more recently among single Traveller women. Some Travellers were aware of 'drink problems' in their community, and reported that such problems were usually dealt with within the family. Service providers felt that because Travellers are discriminated against in certain pubs, they buy cheap alcohol from supermarkets, which contributes to high levels of consumption in the home and at halting sites. They reported that high levels of alcohol use can contribute to violence in the home and when family break-up occurs and 'the head of the house' (usually the male) leaves the family home, the women often resort to alcohol and prescribed medication.

Drugs

Travellers commented that there are visibly 'more drugs' in urban areas in the west in the past two years, and that drugs are increasingly available in the region as a whole in comparison to the situation 10–15 years ago. Ecstasy, speed, hash and cocaine are the drugs most commonly used. Polysubstance use is common, most often in the following combinations: alcohol and hash/cannabis; alcohol and benzodiazepines; benzodiazepines and Solpadeine; Solpadeine and alcohol; cocaine and alcohol; Red Bull and Anadin; Zamadol and Coca-Cola; Anadin and Coca-Cola and painkillers and alcohol. According to service providers, Traveller males use hash, cocaine and ecstasy and Traveller women tend to use prescription medication. Despite some anecdotal reports of heroin (smoking), crack cocaine and cocaine use, the majority of service providers reported little direct evidence to suggest that these substances are widely used.

Levels of illicit drug use among young Traveller women were perceived to be lower than those reported by young women in the general population. This was often attributed to the degree of monitoring, parental control and restriction of income of young women in Traveller communities. However, there were reports that young Traveller women use night sedation medication and benzodiazepines.

Drug dealing

Mixed views existed on the nature and extent of drug dealing in the Traveller community. The general consensus was that it exists but is not widespread and that users tend to obtain their drugs through their own families and have little contact with dealers in the settled community. Some Travellers were concerned that both Traveller and settled drug dealers were recruiting young Travellers to act as 'runners' and were therefore also providing them with an introduction to drugs and context for use.

Drug awareness and information

Travellers felt the level of drug awareness within their community was quite low. Older Travellers viewed illicit drugs as a sensitive and 'taboo' topic. The majority of Travellers who had participated in drug awareness training felt that it was not suitable for a Traveller group, as it was not based on their values and beliefs. The most pervasive theme was the importance of involving the Travellers in drug education and prevention, and taking into consideration their norms and cultural values in the delivery of such services and educational materials. It was remarked that Travellers 'would prefer information from Travellers'.

This research is welcome and builds on what is already known about substance use in the Traveller community. The main findings are similar to those of a 2006 study,² and show that levels of illicit drug use among Travellers are low compared to those in the general population, particularly in the case of Class A drugs such as heroin and cocaine. This research shows the influence of informal 'social controls' that pertain in some Traveller communities. These informal mechanisms are often credited with reducing the use of illicit drugs among young Traveller women, but appear to be less effective in reducing the use of prescription and over-the-counter drugs by young women.

(*Martin Keane*)

1. Van Hout MC (2009) *Substance misuse in the Traveller community: a regional needs assessment*. Galway: Western Region Drugs Task Force.
2. Fountain J (2006) *An overview of the nature and extent of illicit drug use amongst the Traveller community: an exploratory study*. Dublin: National Advisory Committee on Drugs.

Substance use in new communities in the WRDTF area

The third in a series of three research reports commissioned by the Western Region Drugs Task Force (WRDTF) explores substance use among new communities in the west of Ireland and identifies barriers to effective use of services.¹ New communities include migrant workers, refugees, asylum seekers, and migrants who have been granted citizenship. At the time of the 2006 census, there were 48,387 non-nationals living in the west of Ireland.

The authors state that members of new communities in Ireland come from countries where the rates of substance use among adults are generally lower than they are in this country. They note that Irish research and informal reports from service providers suggest that migrant workers and refugees and asylum seekers are not accessing health services in Ireland because of the high cost of these services, lack of insurance, unfamiliarity with the health system and poor English language skills.

WRDTF area – new communities (*continued*)

The authors report that risk factors for substance use in new communities are generally the same as those in other communities, and include mental health issues, social isolation, poor education levels and unemployment. For some members of new communities, post-traumatic stress disorder can interact with experiences of discrimination and social exclusion to increase the risk of substance use. Other factors include the strain of being undocumented, having illegal status, and anxiety about being discovered. Having limited access to medical services except in the case of an emergency can impede access to frontline services such as GPs where substance use may be identified as a problem and treated early.

According to this report, adolescents in new communities can experience isolation due to low levels of supportive peer relationships in school. Additional strain can occur for these young people when they learn new language and cultural practices which reflect the norms of the indigenous population. This may result in a clash with the value system and cultural practices of their family. Taken together, these factors can increase the risk of substance use among young people as they try to fit in with the indigenous culture and deal with social isolation.

The authors interviewed by phone 18 statutory and voluntary groups involved in the support of new communities or the provision of substance use services to explore their perspective on substance use in these communities. Almost all those contacted had no specific or specialist information on the issue, nor did their organisations have policies or strategies to address the issue.

This research included an analysis of regional press coverage of substance use issues in the west, and particularly in new communities, between 8 and 14 December 2008. The results suggest that there is more media interest in alcohol-related issues than in other drug issues and that there is more ambivalence about alcohol (which is presented as

both potentially dangerous and positive and worthy of promotion) than other drugs (which are presented entirely negatively). In relation to the issue at hand, only five articles were identified where members of new communities and alcohol or other drugs were explicitly linked, and just three of those cases concerned drug possession or public drunkenness.

This report mentions a small number of studies on appropriate responses to substance use in new communities. These are highlighted as potential ‘starting points’ for communication among service providers and, according to the authors, are ‘in a sense pragmatic and in some cases “best guesstimates” of what could work’.

The authors uncovered little evidence of substance use as a substantial problem, or one that required immediate action, among new communities in the west of Ireland. However, the reluctance of members of new communities to access health services, as acknowledged in this report, suggests that the views of service providers as to the extent of substance use may not reflect the true situation in the communities. Alternative methods of collecting primary data, such as training people from new communities to undertake in-depth fieldwork, including interviews and observation, may yield a different picture to that conveyed here. A 2004 study using these methods found that heroin and cocaine use were becoming a problem among some sections of new communities in Ireland.²

(*Martin Keane*)

1. Kelly C, Fitzpatrick C and Nic Gabhainn S (2009) *Substance use in new communities: a way forward*. Galway: Western Region Drugs Task Force.
2. Corr C (2004) *Drug use among new communities in Ireland: an exploratory study*. Dublin: National Advisory Committee on Drugs.

Fourth ESPAD survey on substance use among young people

Mary Wallace TD, Minister of State at the Department of Health and Children, announced the publication of the fourth European School Survey Project on Alcohol and Other Drugs (ESPAD) on 26 March 2009.¹

ESPAD surveys have been conducted every four years since 1995, using a standardised method and a common questionnaire. The rationale for these surveys is that school students are easily accessible and are at an age when onset of substance use is likely to occur. (By definition, early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented.) ESPAD survey information is valuable in planning prevention initiatives.

The fourth survey was conducted in 35 European countries during 2007 and collected information on alcohol and illicit drug use among 15–16-year-olds; 2,249 students from 94 randomly selected schools participated, which represents

a response rate of 78%. Fewer schools and students participated in 2007 than in 2003.

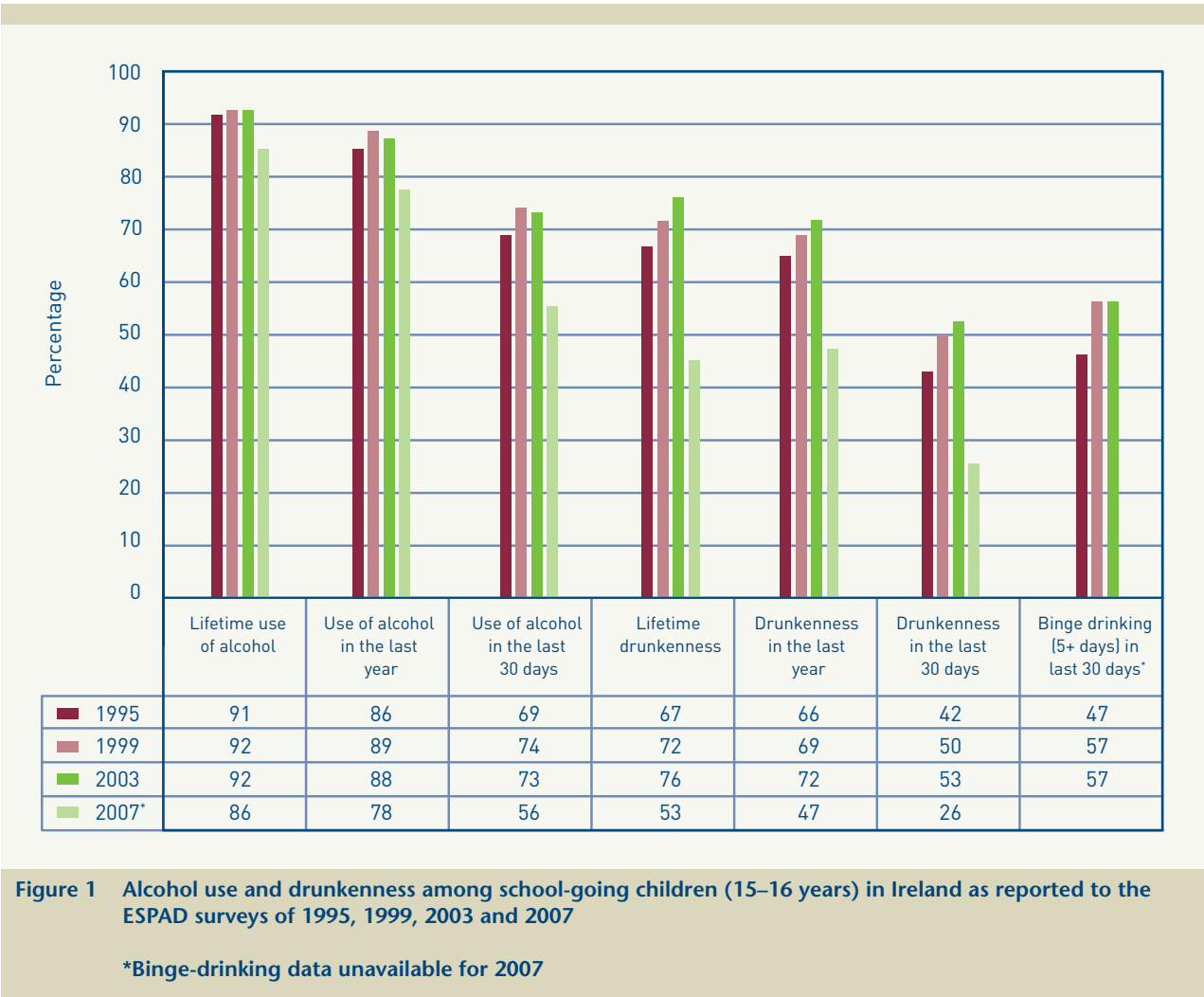
The 2007 survey report acknowledges that problems in the wording of the questionnaire affected the comparability of Irish data in relation to beer and cider consumption, and in relation to binge drinking.² Consequently, this report does not contain Irish data on the volume of alcohol consumed on the last drinking occasion or the frequency of binge drinking.

In terms of alcohol consumption, the Irish data show unusual trends in both alcohol use and drunkenness. Drunkenness increased between the 1995 and 2003 surveys, but decreased considerably in 2007 (Figure 1). The percentage of students who had consumed any alcohol in the past 30 days decreased between 2003 and 2007 (from 73% to 56%), while the percentage who had been drunk in the

ESPAD survey results (continued)

previous 30 days halved (53% in 2003, 26% in 2007). The 2007 European average for alcohol consumption in the last 30 days was 61% (5 percentage points higher than Ireland),

while the European average for drunkenness in the last 30 days was 18% (8 percentage points lower than Ireland).



In terms of drug use, the Irish data show a marked decrease in lifetime use of any illicit drug between 2003 (40%) and 2007 (22%), a fall of 18 percentage points (Table 1). As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Lifetime use of solvents/inhalants

decreased from 18% in 2003 to 15% in 2007, but remained higher than the European average (9%). In the case of both amphetamines and cocaine powder, the proportions reporting lifetime use increased marginally to just above the European average of 3%. In 2007, one in ten of the survey participants reported that they had taken prescribed tranquillisers or sedatives at some point in their lives; the use of such drugs had decreased marginally since 1999.

ESPAD survey results (continued)

Table 1 Proportions of school-going children (15–16 years) in Ireland who reported lifetime use of drugs in the ESPAD surveys of 1995, 1999, 2003 and 2007

	1995 (%)	1999 (%)	2003 (%)	2007 (%)
Lifetime use				
Any illicit drug*	37	32	40	22
Cannabis	37	32	39	20
Inhalants (solvents)	n.a.	22	18	15
Ecstasy	9	5	5	4
Cocaine powder	2	2	3	4
Amphetamines	3	3	1	3
Prescribed tranquillisers or sedatives	n.a.	11	10	10
Non-prescribed tranquillisers or sedatives	7	5	2	3
*includes amphetamines, cannabis, cocaine, crack, ecstasy, heroin and LSD or other hallucinogens				
n.a. = not available				

In another national study, the HBSC (Health Behaviour in School-aged Children) survey,³ lifetime cannabis use among 15–17-year-olds was 29% in 2006 compared to 26% in 2002 and 25% in 1998 (S Nic Gabhainn, personal communication, 2008). The HBSC survey shows a steady marginal increase in cannabis use between 1998 and 2007, whereas the ESPAD survey shows a large increase between

1999 and 2003 and a larger, unexpected decrease between 2003 and 2007 (Figure 2). It is important to investigate the reasons for the fall in alcohol and cannabis use reported in the ESPAD surveys; it could represent a genuine decrease in the use of alcohol and cannabis or a change in the type of sample chosen or the way the questionnaire was administered.

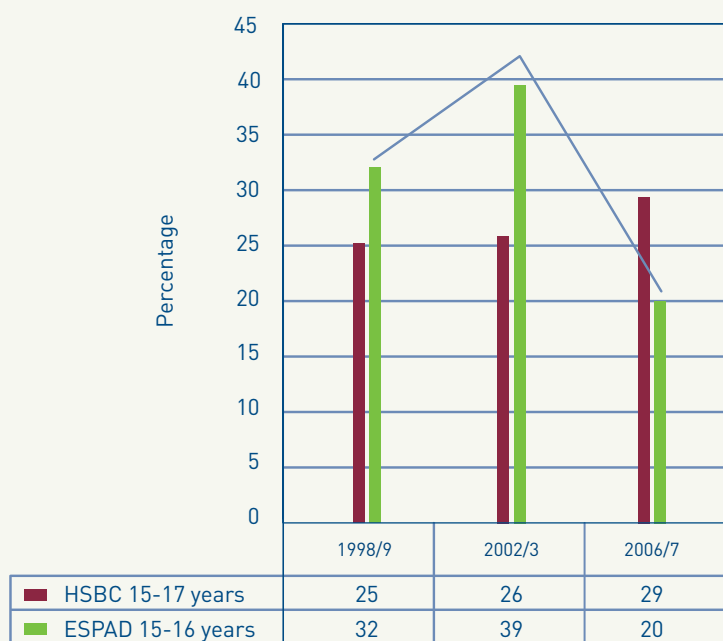


Figure 2 Trends in lifetime cannabis use, as reported by the ESPAD and HBSC surveys at three time points

ESPAD survey results (continued)

(Jean Long and Deirdre Mongan)

1. Hibell B et al. (2009) *The 2007 ESPAD report: substance use among students in 35 European countries*. Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe.

2. These anomalies are explained in the report (pp. 224–225), and concern the fact that Ireland uses both metric
- and imperial measures (litres/pints) and has a wide variety of containers for beer and cider (ranging from 284 ml to 568 ml), the absence of one answer category in the question about spirits consumption, and the lack of a definition of ‘a drink’ in the binge-drinking question.
3. The HBSC (Ireland) survey is conducted every four years by a research team at the Health Promotion Research Centre at the National University of Ireland, Galway, in collaboration with the WHO Regional Office for Europe (see www.nuigalway.ie/hbcs).

Evaluation of work with marginalised youth

The Office of the Minister for Children and Youth Affairs (OMCYA) established an Inclusion Programme in December 2007 aimed at engaging marginalised young people in ‘youth participation structures and processes’. Seven organisations were allocated funding to support such involvement by the young people they represented. An independent evaluation of the first year of the Inclusion Programme has now been published.¹

The seven participating organisations and the number of participants from each organisation involved in the Inclusion Programme and other youth participation projects are shown in Table 1. Grants were offered to these organisations so that they could help young people become involved in structures such as the Children and Young People’s Forum (CYPF)² and Comhairle na nÓg.³ These structures provide a mechanism whereby the views of young people are sought on issues relevant to them, such as recreation policy and youth cafés.

Table 1 Number of young people involved in the Inclusion Programme and other youth participation structures, per participating organisation

	Inclusion Programme	Other participation structures	Total
Barnardos	2	0	2
BeLonG To Youth Service (an organisation for lesbian, gay, bisexual and transgendered (LGBT) young people)	1	2	3
Ferns Diocesan Youth Service (FDYS)	37	10	47
Inclusion Ireland (National Association for people with an intellectual disability)	2	0	2
Irish Association of Young People in Care (IAYPIC)	4	0	4
Irish Wheelchair Association (IWA)	12	1	13
Pavee Point (Traveller organisation)	10	5	15
Total	68	18	86

Source: McEvoy 2009

Programme evaluation and data collection methods
Site visits were made to six of the organisations and the evaluator conducted face-to-face interviews and a number of telephone interviews with key stakeholders in all seven organisations, including 21 young people, and 11 adults who were youth leaders, project leaders, steering committee representatives or directors of the organisations. Each organisation submitted two progress reports during the first year of operation.

Level of participation by young people
Sixty-eight young people were involved in projects specifically relating to the Inclusion Programme and a further 18 were involved in other youth participation structures. More than half of the total number is accounted

for by the high numbers attending the Ferns Diocesan Youth Service in Wexford. The evaluator states that the numbers involved are a ‘simple and important criterion’ of success; however, it must be noted that in most cases the numbers were small. This may reflect the ‘bedding down’ time it takes to initiate this type of intervention and to attract marginalised young people.

Key findings from evaluation
The young people interviewed identified the benefits of participation in the Inclusion Programme and other youth participation projects in terms of opportunities – to get involved; to have a voice; to make new friends and understand different points of view; to improve personal skills, such as communication, confidence and team

Work with marginalised youth (*continued*)

working; and to feel a sense of achievement. The evaluation notes that the personal stories of the young people are testament to a programme that was well organised, well supported and meaningful and the ultimate benefit was that young people felt empowered and valued in the projects, as reflected in comments such as: 'you are not judged on your background' and 'people don't treat you differently'.

The evaluator states that the achievements of this programme represent progress in a short space of time. However, continued commitment and drive is required from the OMCYA and participating organisations to ensure that young marginalised people continue to benefit from engaging in youth participation structures, and that such structures benefit from integrating the views of young people on issues affecting their lives.

(*Martin Keane*)

1. McEvoy O (2009) *Evaluation report on the inclusion programme*. Dublin: Office of the Minister for Children and Youth Affairs.
2. The Children and Young People's Forum (CYPF) was established in 2004 to advise the OMCYA and the Minister for Children on issues of concern to children and young people. Thirty 12–18-year-olds from all over the country participate in the Forum.
3. Comhairle na nÓg is a network of local youth councils which give children and young people the opportunity to be involved in the development of local services and policies.

A new model of progression for recovering drug users

The Working Group on Drugs Rehabilitation¹ recommended that factors that make it difficult for recovering drug users to access education should be identified and removed where possible. Soilse, the addiction rehabilitation service of the Health Service Executive (HSE), has been involved in identifying obstacles to further education for clients for quite some time. During this work a recurring theme emerged in relation to clients who were attending mainstream educational institutions. Because of negative experiences of the education system when they were young, many clients of Soilse do not have the necessary 'educational capital' to engage actively with the demands of academic study. The average school-leaving age of Soilse participants is 15.5 years; many have pronounced literacy difficulties and almost all are dependent on social welfare.²

To address this issue, Soilse, in collaboration with NUI Maynooth, developed a Return to Learning (RTL) programme to empower and support former Soilse participants to tackle these obstacles and progress to further education. Using an integrated literacy approach, the RTL programme sought to prepare a group of 12 participants for college by simulating college conditions and providing technical, personal development, group-based learning, study and time management skills, and knowledge transfer. The pilot ran from June to September 2008 and was funded by the HSE, the City of Dublin Vocational Education Committee (CDVEC) and FÁS.

The rationale behind the RTL programme was twofold. First, and most important, it enabled participants to develop the skills and confidence to undertake, enjoy and succeed in a post leaving cert (PLC), institute of technology or university course. Second, it provided a 'structure' from the time participants completed Soilse's six-month drug-free programme until their third-level course started, typically in September.

In Soilse's experience, it is vital for people in early recovery to have a structure in their daily lives – something to do each day and somewhere to be. Without this, people are more likely to slip into old patterns of behaviour or social networks, with the risk of relapse. Taking up employment

while waiting to start college is generally not an option as this can affect participants' eligibility for the Back to Education Allowance (BTEA), and Vocational Training Opportunities Scheme (VTOS) and Higher Education Authority (HEA) grants.

Feedback from RTL participants was that the programme met their personal and learning needs. They found the requirements around time-keeping, attendance, studying and completing assignments challenging but they gained technical skills in structuring assignments, sourcing information, using computers and becoming familiar with material they would encounter in college. They also made personal gains in becoming more reflective, self-assured, analytical and realistic about college expectations.

At a three-month follow-up, eight of the 12 RTL participants were enrolled in PLC courses, one was in Trinity College's Access Programme, one was working and studying part-time, one was awaiting a FÁS course and one was unemployed. All reported that they were not using drugs.

This high success rate indicates how a targeted and supportive educational skills development programme can help former drug users to overcome the barriers to social integration. From Soilse's perspective, the RTL programme provided an excellent and cost-effective use of once-off funding, enabling participants to progress into education, which is a bridgehead to career independence.

This pilot represents an important advance in understanding the obstacles to education for recovering drug users and in identifying how to respond effectively to these challenges. In particular, the lessons learned from this pilot can serve as an important contribution to the implementation of the recommendations of the Working Group on Drugs Rehabilitation regarding education for recovering drug users.

(*Sandra Burke and Martin Keane*)

1. Working Group on Drugs Rehabilitation (2007) *National Drugs Strategy 2001–2008: Rehabilitation*. Dublin: Department of Community, Rural and Gaeltacht Affairs.
2. Information supplied by Soilse (www.soilse.ie).

Family Support Network re-launched

The Family Support Network (FSN) was launched as an independent national organisation at a ceremony in Dublin's Mansion House on 26 March. Speaking at the launch, Sadie Grace, FSN Coordinator, highlighted the role of family support services in dealing with the problem of drug use. 'These services need adequate funding and resources if they are to develop', she said.

John Curran TD, Minister with responsibility for drugs strategy, paid tribute to the staff and management committee of FSN and said 'It is clear that the Network has put immense effort into the provision of vital information and support to members, families and communities.'

Professor Des Corrigan, Chairperson of the National Advisory Committee on Drugs, spoke of FSN's progress from a small number of groups, mainly in Dublin, to a nationwide organisation and congratulated family members on their commitment and dedication since the network was established in 2000. Marian Davitt, a founding member of the FSN group in Bray, highlighted the benefits family members received from attending the group.

Also attending the launch were the Lord Mayor of Dublin, Councillor Eibhlin Byrne, Archbishop Diarmuid Martin, and Chief Superintendent John O'Driscoll, representing Garda Commissioner Fachtina Murphy.

FSN now has its own premises in a central Dublin location. The new website, www.fsn.ie, will provide accurate information for families who want to learn about addiction, its effect on the family and the supports that are available for



At the launch were (l to r) Minister of State John Curran TD, Sadie Grace of FSN, Archbishop Diarmuid Martin and Lord Mayor of Dublin, Councillor Eibhlin Byrne (Photo: courtesy Lord Mayor's Office)

families. It will also act as a resource for new and established family support groups and networks.

(Brian Galvin)

For further information contact Sadie Grace at FSN: (01) 8365 168 / (087) 983 4810.

Women speak about their drug-related problems

To mark International Women's Day (8 March), the EMCDDA published a collection of narratives from women facing drug-related problems.¹ While it is estimated that, in Europe, around one in four drug users entering treatment is female and women account for one in five drug-related deaths, most drug services in Europe are designed with male drug users in mind. The EMCDDA's new thematic paper presents quotations gleaned from interviews conducted between 2000 and 2008 with women in eight EU member states. They illustrate how qualitative research can yield insights into the experiences and perceptions of women facing drug issues that statistics alone cannot provide and that can help in designing services that better meet the needs of a sizeable proportion of clients.

The thematic paper identifies five key issues.

1. The confusion and desperation that mothers experience when their own children develop drug problems.
2. The deprivation and abuse that characterise the lives of many women who develop drug problems.
3. The difficulties faced by drug-using women who attempt to fulfil societal roles as mothers and provide the sort of childcare they and 'society' wish for children.

4. The plight of women drug users in prison — the most vulnerable of all women.

5. Stigma, policies and practices that make it difficult for women to access treatment.

In a previous EMCDDA report, which undertook a gender-based analysis of quantitative data on drug use and responses to drug problems in EU member states, it was concluded that 'policymakers, professionals and scientists must always take gender into consideration in the planning of research, analysis, interventions and policy in the drugs field.'² Using qualitative data, this new thematic paper spells out just how interventions for female drug users might be tailored:

... there is a need for holistic interventions for female drug users. ... the overarching theme illustrated by the quotations is about the struggle that female drug users face in fulfilling their social roles. Some of their quotations are invocations for improved services to alleviate their drug problems and provide them with necessary social support but it is important to recognise that other quotations are invocations for finding ways to reduce the stigma imposed on them and recognising their achievements in controlling their drug use and fulfilling their social roles. (p. 18)

Women and drug-related problems (continued)

The EMCDDA did not use Irish sources in compiling this thematic paper. However, a number of studies of the drug problem in Ireland have included qualitative data on Irish women's experiences and perceptions of their drug-related

problems. The authors of these studies have highlighted their potential to inform policy decisions. A selection of these studies is listed below.

(Brigid Pike)

Recent studies containing qualitative data on the experiences and perceptions of Irish women facing drug-related problems³

- Comiskey CM, O'Sullivan K and Cronly J (2006) *Hazardous journeys to better places: positive outcomes and negative risks associated with the care pathway before, during and after an admittance to the Dóchas Centre, Mountjoy Women's Prison, Dublin, Ireland*. Dublin: Health Service Executive.
- Coveney E, Murphy-Lawless J, Redmond D and Sheridan S (1999) *Prevalence, profiles and policy: a case study of drug use in north inner city Dublin*. Dublin: North Inner City Drugs Task Force. (Includes an extended case study interview with a 26-year-old recovering female addict.)
- Hunter P (2004) An investigation into the lifestyle, risk behaviours and health care needs of street-based female prostitutes in Belfast, Northern Ireland. PhD Thesis, University of Ulster.
- Lawless K and Wayne A (2005) *The Next Step Initiative: research report on barriers affecting women in prostitution*. Dublin: Ruhama.
- Lawless M (2003) Private lives – public issues: an investigation into the health status of female drug users. In *Pieces of the jigsaw: six reports addressing homelessness and drug use in Ireland*. Dublin: Merchants Quay Ireland.
- Murphy-Lawless J (2002) *Fighting back: women and the impact of drug abuse on families and communities*. Dublin: Liffey Press.
- O'Kelly EM (2005) Study on the perceptions of female drug users in relation to the consequences of parental substance abuse on the children of the substance misusers. MSc Thesis, Dublin City University.
- Woods M (1999) Women, drug use and parenting in Dublin: the views of professional workers in the drug treatment and social work fields. Paper presented at 10th annual European Society for the Study of Drug Use (ESSD) Conference on Drug Use and Drug Policy in Europe, held in Vienna in September 1999.

1. EMCDDA (2009) *Women's voices: experiences and perceptions of women who face drug-related problems in Europe*. Thematic paper. Luxembourg: Office for Official Publications of the European Communities.
2. EMCDDA (2006) *A gender perspective on drug use and responding to drug problems*. Selected issue. Luxembourg: Office for Official Publications of the European Communities. Ireland's input to this selected issue is contained in the 2005 Annual Report to the EMCDDA, which may be accessed at www.ndc.hrb.ie (Drugs in Ireland page).
3. This selection is taken from the electronic database administered by the National Documentation Centre on Drug Use (NDC) at www.ndc.hrb.ie. On 23 March 2009, a search of the database was undertaken, using the keyword 'women'; 121 items were retrieved, 96 of which were general reviews, research reports and policy documents relating to substance misuse, including alcohol and tobacco, in Ireland. The majority of the research reports described quantitative studies of, for

example, the epidemiology of female problem drug use, risk behaviours, infectious diseases, homelessness and comorbidity among cohorts of female drug users, and the effects of drug use on pregnancy. Among the small number of reports containing qualitative data, a selection of those published in the last 10 years is listed here. For a survey of earlier Irish research studies, including qualitative studies, see E Farrell (2001) *Women, children and drug use*. In R Moran *et al.* *A collection of papers on drugs issues in Ireland*. Dublin: Health Research Board.

Mental health and well-being of LGBT people – the role of alcohol and drugs

On 2 February 2009 an exploratory study of the mental health and well-being of lesbian, gay, bisexual and transgender (LGBT) people in Ireland was published. Commissioned by the Gay and Lesbian Equality Network (GLEN) and BeLonG To Youth Services, and funded by the Health Service Executive's National Office for Suicide Prevention, the research was undertaken by a team of researchers from TCD, UCD and UCC.¹

The purpose of the study was to examine mental health and well-being, including an investigation of suicide vulnerability (risk) and resilience, among LGBT people in Ireland, and to make recommendations on policy, service delivery and practice related to mental health promotion and suicide prevention.

The researchers used the 'minority stress model' to aid their understanding of the negative impacts on health and well-being caused by a stigmatising social context. External stressors were found to include presumed heterosexuality, homophobia, prejudice and victimisation; internal stressors related to the anxiety of coming out. Negative reactions from others when an individual 'came out' to them also featured, as did the stress of self-concealment.

The findings on mental health indicators suggested that the stigma and discrimination encountered by LGBT people can result in an extremely negative experience of being LGBT. Many participants in the study described having experienced depression, and a significant minority reported engaging in self-injurious behaviour, including hazardous drinking or problem alcohol use, and suicidal thoughts.

The 'resilience narratives' of LGBT individuals were explored, with special reference to self and others, and also in relation to the social environments or contexts where LGBT people interact. Four key sources of social resilience were discerned – friends, family, the LGBT community, school and the work place.

With regard to 'self-resilience', the researchers found evidence to suggest that resilience is an ongoing and emerging process rather than simply a trait possessed by some LGBT individuals and not by others. Positive life experiences and turning points were observed to have led to greater self-esteem and self-efficacy among participants. Many also identified 'coping strategies' that they used to alleviate stress. Six of the 20 coping strategies listed in the survey instrument related to the use of licit and illicit substances, and participants (N=1,110) identified using these strategies as follows:

- drink alcohol to get drunk 28.2% (n=313)
- drink alcohol (not to get drunk) 25.5% (n=283)
- smoke cigarettes 24.5% (n=272)
- take medication prescribed by a doctor/psychiatrist (e.g. anti-depressants) 17.3% (n=192)
- take prescription drugs (without advice of a doctor or medical worker) 12.3% (n=136)
- take illegal drugs 10.0% (n=111)

The researchers concluded that social and structural factors play a significant role in determining the mental health of LGBT people. Their recommendations therefore focused on measures to achieve institutional and social change. For example:

- the needs of LGBT people should be integrated into all health policies and strategies, including policies and strategies on alcohol and drug (mis)use;
- health, mental health and social services should be provided in a way that is accessible and appropriate to LGBT people;
- specific attention should be paid to the needs of transgender people within health policy;
- health professionals should be trained both to understand how an LGBT identity is a potential risk factor for self-harm, suicidal behaviour and depression, and to have cultural competency specific to the LGBT population;
- LGBT-specific groups and organisations nationally, and front-line responses such as the voluntary LGBT helplines throughout the country, should be resourced to engage in mental health promotion and suicide prevention work.

The researchers identified opportunities for positive intervention and change at the personal and interpersonal levels in the education and youth-work sectors, and within families. They recommended, for example, increasing the recognition of LGBT needs and issues in the SPHE (Social, Personal and Health Education) curriculum and in early-school-leaving policies and programmes, and increasing awareness, training and resourcing of teachers, youth workers and family members who work with LGBT young people, in order to ensure they can support them in developing confidence and self-esteem.

With regard to research, the authors recommended that, in future, all national administrative databases, general population surveys, and longitudinal and other large-scale survey research on children, young people and families should, as a matter of course, include items that can capture, or questions on, sexual orientation, gender identity and same-sex partnership and cohabitation.

(Brigid Pike)

1. Mayock P, Bryan A, Carr N and Kitching K (2009) *Supporting LGBT lives: a study of the mental health and well-being of lesbian, gay, bisexual and transgender people*. Dublin: National Office for Suicide Prevention. Retrieved on 25 April 2009 at www.tcd.ie/childrensresearchcentre. The research adopted a multi-modal approach, including the administration of a primarily quantitative on-line survey, and the conduct of a community assessment process and of in-depth individual interviews with 40 individuals who identified as LGBT.

Alcohol's role in traumatic brain injury

A recent study has reported that alcohol is associated with one in four traumatic brain injuries (TBIs) in Ireland.¹ Trauma is the leading cause of death in Irish people aged under 45, and for every traumatic brain injury death at least two people survive with a permanent disability, which has as yet unmeasured personal, societal and economic consequences.

This study analysed the records of 2,095 patients attending the two neurosurgical units in Ireland – Beaumont Hospital and Cork University Hospital – over a two-year period. Men

were three times more likely to be injured than women and one in six patients was aged between 16 and 24 years.

Factors contributing to TBI, including alcohol and drug use, were studied. Alcohol was involved in one in four TBIs. However, there was inadequate recording of alcohol use in 60% of medical notes, and 85% had no data on drug use. Only 1.3% of patients were documented as having used recreational drugs prior to sustaining their injury.

Table 1 Involvement of alcohol in TBI, by accident type

Accident type	Alcohol involved
Fall	24%
Injury at home	27%
Road user injury	21%
Alleged assault	59%
Sports injury	7%
All types	24%

The authors' recommendations include introducing awareness strategies to highlight the increased risk of serious injury associated with alcohol use. The report also suggested that drug use and its impact on TBIs is an area which needs improved documentation and further exploration.

(Deirdre Mongan)

1. Traumatic Brain Injury Research Group (2008) *National report on traumatic brain injury in the Republic of Ireland 2008*. Phillips report. Dublin: Traumatic Brain Injury Research Group.

RADE launches debut film, *Today*

RADE, a drug recovery project, launched their short film, *Today*, followed by a 'behind the scenes' documentary on 26 May 2009 in the Irish Film Institute in Temple Bar. The film tells the story of Patrick, who is sent by his eccentric doctor to find an arts project in Dublin's inner city. *Today* is an engaging, funny and moving short film that introduces both Patrick and the audience to the colourful characters that have found a home in the 'Art Row Workshop'. The film was written and directed by Pom Boyd in collaboration with RADE participants.

The Minister of State with responsibility for drugs strategy, John Curran TD, attended the launch. The Minister, a fan of the arts himself, highlighted the importance of rehabilitation and the need to perceive the rehabilitative process as much more than just a medical intervention but as a process of rebuilding lives through participation in projects such as RADE. Michael Egan, RADE's project manager, underlined how projects such as *Today* were needed to counter the negative stereotype of drug users – people with drug problems can and do make positive contributions to society. It is hoped to screen the film over the next 12 months at different venues and projects around the country.



Director Pom Boyd, Nicola Clifford and Robbie Keane (cast members) during the Q & A session at the RADE event. (Photo: courtesy RADE)

(Anne Marie Donovan)

For further information about RADE, see www.rade.ie; email info@rade.ie

Guidelines on 'quasi-compulsory' treatment

Quasi-compulsory treatment (QCT) refers to any form of drug treatment that is ordered, motivated or supervised by the criminal justice system. The Council of Europe's Pompidou Group (Criminal Justice Platform) commissioned a survey to ascertain what existing guidelines were employed by various jurisdictions when making QCT orders or recommendations for adult drug-dependent offenders.¹ Of the 35 Council of Europe states requested to participate, 22 countries (including Ireland) provided responses.

Three-quarters (16) of the responding countries had national legislation in place to govern the implementation of QCT measures (Ireland was not one of these countries). Of these 16 countries, five had adhered to all or most of 13 established best practice principles and only one adhered to no such guidelines. Best practice principles related to eligibility, compliance monitoring, client rights, funding, programme objectives and treatment philosophy. Specific national guidelines for QCT, aimed at informing both health and criminal justice professionals, existed in 11 countries (not including Ireland). These national guidelines related to different stages of the criminal justice process, including arrest, court (pre-sentence), prosecution, imprisonment and post release. Eight of these jurisdictions had developed guidelines to evaluate the use of QCT.

On the whole, the results of the survey were deemed encouraging but the variety of approaches among member states suggested the need to develop a transnational set of guidelines on QCT practices. It was also concluded that there was scope for legislation in the six responding

countries (including Ireland) where legislation was absent. Of these countries, several had prison systems operating at or above capacity.

The primary form of QCT available in Ireland is that offered by the Irish Drug Treatment Court (DTC). The DTC, established as a permanent court in 2006 after a five-year pilot phase, deals with offenders who have either pleaded guilty or been convicted of minor crimes committed as a consequence of drug abuse. Addressing a European conference on QCT and other alternatives to imprisonment in October 2007, Judge Bridget Reilly of the DTC said: 'Despite the low graduation numbers, the progress and improvement in quality of life for the participants is seen to be very significant by the DTC team, considering the background of low literacy skills, low educational participation, and often difficult social and family history.'² The DTC was due to be expanded to other areas under the National Drugs Strategy 2001–2008, which is currently under review.

(Anne Marie Donovan and Johnny Connolly)

1. McSweeney T (2008) *Guidelines on the 'quasi-compulsory' treatment of adult drug dependent offenders: results from a survey of Council of Europe member states*. London: Kings College. Available at www.coe.int/t/dg3/pompidou/
2. Connolly J (ed.) (2007) The Irish drug treatment court – a view from the bench. *Drugnet Ireland*, (24): 22.

Reports examine effects of decriminalisation of drugs in Portugal

Portugal became the first country in the European Union to decriminalise all drugs, including cocaine and heroin, under a statute passed in 2000.¹ Although drug possession for personal use and drug usage itself are still legally prohibited in Portugal, violations of these prohibitions are deemed exclusively administrative violations and are removed from the criminal process. Drug trafficking continues to be prosecuted as a criminal offence. The law, according to a report commissioned by the Beckley Foundation,² 'formed part of a strategic approach to drug use which aimed to focus police resources on those people who profit from the drugs trade, while enabling a public health approach to drug users' (p. 2). A recent analysis of the legal reforms by the US-based Cato Institute³ has concluded that 'judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success' (p. 2).

Although several EU states have developed either formal or de facto forms of de-penalisation, particularly for personal cannabis use, whereby offenders seldom receive custodial sanctions, no EU state except Portugal has explicitly decriminalised drugs. Under the statute, decriminalisation

applies to the consumption, purchase and possession of all drugs for 'one's own consumption', which is defined as a quantity 'not exceeding the quantity required for an average individual consumption during a period of ten days' (Article 2). No distinction is made between drug types or between public and private consumption.

The statute establishes Commissions for the Dissuasion of Drug Addiction (CDTs) to adjudicate and impose appropriate sanctions for violations of the new law. The CDTs comprise three members appointed jointly by the ministries of justice and health and the government's co-ordinator of drug policy, whereby one will have legal training and at least one of the other two will have a medical or social services background.

Article 15 sets out the authorised administrative sanctions, which can include warnings and/or fines of an amount between €25 and the minimum wage. In the absence of evidence of addiction or repeated violations, the imposition of a fine is to be suspended. The CDT can also suspend sanctions on condition that the offender attends treatment. The Cato report points out that it is difficult to enforce such

Decriminalisation in Portugal *(continued)*

conditions in practice 'since violations of a commission's rulings are not, themselves, infractions of any law' (p. 3).

Where offenders are deemed to be addicted to drugs, the CDT can impose a range of other sanctions, including, as summarised in the Cato report, 'suspension of the right to practise a licensed profession (doctor, lawyer, taxi driver); a ban on visiting high-risk locales (nightclubs); a ban on associating with specified individuals; ... prohibitions on travel abroad' (p. 4). In determining the appropriate sanction, the CDT must consider factors such as 'the seriousness of the act; the type of drug consumed; whether consumption was public or private; and whether usage is occasional or habitual' (p. 4). However, providing drugs to a minor (or to a person with mental illness) is considered an aggravating factor under the general prohibition of trafficking, which is punishable by imprisonment of between four and 12 years.

Police officers who observe drug use or possession are required to issue citations to the offender, but they are not permitted to make an arrest. The citation is sent to the CDT and the administrative process then commences. The Cato report notes that the reaction of police officers to the initiative has been mixed, with some believing that 'the issuance of citations, without arrest or the threat of criminal prosecutions, is worthless' (p. 4), while other officers are now more inclined to act when they see drug use because they believe the new regime and the types of treatment it offers are a more effective response to personal drug use. The Beckley Foundation report described the nature of the support for the latter view:

The law enforcement sector was seen as supportive of the reform, particularly because they perceived decriminalization and referral to education and treatment as offering a better response to drug users than under the previous legislative approach. Key informants asserted law enforcement have embraced the more preventative role for drug users. (p. 6)

According to the Cato report, there were 3,192 CDT rulings in Portugal in 2007. Of these, 83% suspended the proceedings; 15% imposed actual sanctions; and 2.5% resulted in absolution or dismissal. Cannabis continues

to be the substance for which the greatest percentage of drug offenders are cited. Despite fears expressed by those opposing the reform prior to 2001, decriminalisation has not led to an increase in drug use. On the contrary, lifetime drug prevalence rates have decreased in Portugal since the reform. For the critical age groups of 13–15 years and 16–18 years, 'prevalence rates have declined for virtually every substance since decriminalization' (p. 12). Furthermore, the author links a fall in the numbers of new cases of drug-related HIV and AIDS, hepatitis B and C infection, and drug-related death to the coming into effect of the law in 2001. Although he acknowledges that these trends started prior to 2001 and were due in part to education reforms and harm reduction initiatives introduced in Portugal, he suggests that the removal of the fear and stigma of arrest and prosecution incentivised drug users to avail of these new treatment and education initiatives.

The analysis by the Beckley Foundation sounds a more cautious note, which probably accurately reflects the current debate about decriminalisation in Portugal:

Decriminalization has enabled earlier intervention and more targeted and therapeutic responses to drug users, increased collaboration across a network of services and increased attention to adopting policies that work. ... Yet, key informants also highlighted that impacts were less than expected and that there were concerns over the message that decriminalization was sending to new drug users.

(Johnny Connolly)

1. Law 30/2000 of 16 November 2000 came into force in Portugal on 1 July 2001. Published online in the official gazette, *Diário da República* (DR), No. 276, pp. 6829–6832.
2. Hughes C and Stevens A (2007) *The effects of decriminalization of drug use in Portugal*. Briefing paper 14. Oxford: The Beckley Foundation. Available at www.beckleyfoundation.org
3. Greenwald G (2009) *Drug decriminalization in Portugal: lessons for creating fair and successful drug policies*. Washington DC: Cato Institute. www.cato.org

A report on global illicit drug markets

One of the most comprehensive reports on the global illicit drug market was recently published by the European Commission. The report was researched and written by an international team of experts and timed to coincide with and inform the 2009 session of the Commission on Narcotic Drugs in Vienna.¹ Specifically, the study sought to determine whether progress had been made in relation to the UN General Assembly (UNGASS 98) declaration and action plans aimed at rolling back drug abuse and trafficking worldwide.

Data were collected from 18 countries, including western, developing and so-called transitional states. The study employed a largely economic approach and looked at the drugs issue as if it were a licit market. It concludes, rather pessimistically, that 'the relationship between drug policy and changes for the better in drug use or drug problems is

marginal at best. The strongest evidence for this conclusion is the marked similarity in drug trends in countries with very different drug policies' (p. 21).

As well as the main report *Assessing changes in global drug problems 1998–2007*, the work contains six sub-reports and 18 country reports.² The sub-reports cover the following topics:

- The operation of the global drug market
- Estimating the size of the global market: a demand-side approach
- Issues in estimating the economic cost of drug abuse in consuming nations

Global illicit drug market (*continued*)

- The drugs problem and drug policy, developments between 1998 and 2007
- The unintended consequences of drug policies
- Methodological challenges in the country studies

The study found no evidence that the global drug problem had reduced during the UNGASS period from 1998 to 2007. Some of its key findings are considered below.

The geography of drug production

Production of cocaine is increasingly centred in Colombia, and of opiates in Afghanistan. More than 170 countries produce cannabis and cultivation is increasingly found to be indoors and in small plots. Amphetamine-type substances are mainly produced in the Netherlands (ecstasy), Russia (amphetamine) and Myanmar (methamphetamine).

The geography of consumption

Cannabis use has declined on a global level as prevalence rates have fallen from 2002 onwards. Frequent heroin use has declined in western industrialised states,³ but has increased in Russia and Central Asia. Cocaine prevalence rates have declined in the US while increasing in Europe. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) estimates that the number of drug-related deaths in Europe doubled between 1990 and 2000, but fell by 15% between 2000 and 2005.

The size and profitability of the global market

The study concludes that the United Nations Office on Drugs and Crime (UNODC) estimate of the size of the global market (€280 billion) is inflated. Though illicit drug markets generate more than €100 billion in sales, the vast majority of those involved make relatively modest incomes. Retail prices for heroin and cocaine have fallen in the US over the last 20 years and in Europe over the last five years, despite a big increase in incarceration of heroin and cocaine sellers.

Drug policy

Countries take different approaches to controlling the use of illegal drugs: the US and Russia employ largely punitive

policies, while the Netherlands and Switzerland regard the enforcement of criminal law as a last resort. Harm reduction has gained acceptance in a growing number of countries, including China and Iran. Iran has had in the past some of the harshest policies on drug use, but now sanctions the provision of methadone to over 100,000 opiate users.

The report indicates that supply control policies tend to redistribute rather than suppress drug production, trafficking and market activity, and have other unintended consequences, such as an increase in violent killings and the disruption of parent-child relationships due to incarceration policies. Ultimately, there is little evidence that national level supply control policies have had much success. Although global seizures, as a share of estimated global production, have risen substantially for both cocaine (from 23% in 1998 to 42% in 2007) and heroin (from 13% in 1996 to 23% in 2006), the lowering of price at consumption level throughout most regions would indicate that there remains a plentiful supply of illegal drugs from farm gate or factory to the street-level drug seller.

The first comprehensive study of the Irish illicit drug market is currently being carried out by the Health Research Board. Commissioned by the National Advisory Committee on Drugs, this study is due for publication in 2010.

(Johnny Connolly and Anne Marie Donovan)

1. Reuter P and Trautmann F (eds) (2009) *A report on global illicit drug markets 1998–2007*. Report by the Trimbos Institute and RAND for the European Commission Directorate-General for Freedom, Justice and Security. Brussels: European Commission.
2. The country reports feature Australia, Brazil, Canada, China, Colombia, Czech Republic, Hungary, India, Mexico, the Netherlands, Portugal, Russian Federation, South Africa, Sweden, Switzerland, Turkey, the UK and the US.
3. The 2008 EMCDDA report states that new recruitment to heroin use is still occurring at a rate that will ensure that the problem will not decline significantly in the foreseeable future.

EXASS Net

On the initiative of the Finnish Presidency of the EU in 2006, a European network of multi-agency partnerships tackling drug problems at front-line level was established in 2007. Called EXASS Net, the network is managed by the Pompidou Group of the Council of Europe.¹

The fourth EXASS Network meeting was held in Moscow in October 2008. The two-day programme included visits to the clinic of the National Research Centre on Addictions, the Moscow Scientific Practical Centre of Narcology and the Moscow State Technical University, and a number of presentations on different aspects of the Russian Federation's response to drug use and misuse. Representatives of the EXASS Net Steering Group made presentations on the activities of the Pompidou Group, the European Forum for Urban Safety and the Correlation network.

The fifth EXASS Net meeting took place in Budapest, Hungary, and looked at the issue of youth drug cultures, party drugs and club scenes. Future meetings are scheduled for Amsterdam and Oslo. These meetings will consider subjects including the role of drug users in developing responses, cannabis consumption and the role of outreach in response to drug problems.

(Johnny Connolly)

1. More information about the EXASS Network and online reports of its meetings and other activities can be found at www.exass.net

In brief

In January 2009 the **European Society for Social Drug Research (ESSD)** launched its website. Founded in 1990 as an association of European social scientists working on drug issues, the ESSD's principal aim is to promote social science approaches to drug research, with special reference to the situation in Europe. Its 2009 conference will be held in Belfast in September. www.essd-research.eu

Between January and March 2009 the **Employee Assistance Programmes Institute (EAPI)** hosted three seminars in Waterford, Galway and Dublin, on complying with Section 13 of the Safety, Health and Welfare at Work Act 2005, relating to drugs and alcohol at work. The EAPI reports that the Health and Safety Authority (HSA) has indicated that regulations on employee drug testing will not be introduced. Instead, the HSA will issue guidance after a period of consultation with interested parties. www.eapinstitute.com

On 2 February 2009 **INTERPOL** and the **World Anti-Doping Agency (WADA)** signed a memorandum of understanding regarding co-operation in tackling the use of performance-enhancing drugs in sport. The INTERPOL Secretary-General commented, 'While doping is often viewed as a crime committed by an individual, the reality is that when an athlete takes illegal performance-enhancing drugs, this is just one piece in a larger network of criminality.' www.interpol.com/www.wada-ama.org

On 5 March 2009 the **Housing (Miscellaneous Provisions) Bill 2008** was introduced into Dáil Éireann for its second reading. Section 35 of the Bill requires each local housing authority to adopt a strategy for the prevention and reduction of anti-social behaviour in its housing stock. The Bill also amends the definition of anti-social behaviour in the Housing (Miscellaneous Provisions) Act 1997, extending it to include damage to property, graffiti and significant impairment of the use or enjoyment of a person's home. www.oireachtas.ie

On 9 March 2009 the fifth **Joint report on social protection and social inclusion** was jointly adopted by the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council and the European Commission. Regarding the impact of the economic recession on member states of the EU, the report stated, 'The most badly hit victims of the crisis will be those households where breadwinners are at a disadvantage in the labour market and in society. Hence the need for social safety nets which are tight enough to prevent people from falling through and effective enough to launch them back into active social and labour market participation.' http://ec.europa.eu/employment_social/spsi/index_en.htm

On 10 March 2009 the **National Economic and Social Council (NESC)** stated that, as well as banking, fiscal, economic and reputational crises, Ireland faces 'a social crisis of unemployment, income loss and indebtedness'. The Council argued that it was critical to protect those experiencing loss of employment, income, savings and pensions through holding a Jobs and Skills Summit. At this summit, the labour market authorities, and all bodies with a capacity to deliver high-quality, market-relevant training and education programmes, would identify and implement a set of measures that (1) re-order and re-fashion existing education, training and social welfare budgets to more effectively help workers losing their jobs and those seeking jobs for the first time during the recession, and (2) create '21st-century' equivalents to the special labour market programmes introduced in the late 1980s and early 1990s. www.nesc.ie

On 12 March 2009 **Dublin City Business Improvement District (DBID)** announced details of a new long-term partnership with the **Ana Liffey Drug Project (ALDP)**. It will work with the ALDP in developing long-lasting solutions to reduce the problems for those directly affected by problematic substance misuse and homelessness and for the broader community in the city centre. www.aldp.ie

In March 2009 the **National Economic and Social Forum (NESF)** published a report on the **5th Social Inclusion Forum (SIF)**, held in Dublin on 26 November 2008. The SIF was established by Government to provide an opportunity for a wide range of voluntary groups and individuals at local level to present their views and experiences, ideas and proposals, on key policies and implementation issues relating to the National Anti-Poverty Strategy (NAPS). With regard to facilitating employment participation by those vulnerable to exclusion from the labour market, the Forum suggested: (1) address discrimination among employers and service providers towards disadvantaged groups; (2) ensure appropriate progression pathways are available; (3) focus measures and services on those who are most distant from the labour market; and (4) co-ordinate policies, organisations and incentives at the local and national level. www.nesf.ie

On 9 April 2009 **headshops** were the subject of a Parliamentary Question. Minister for Health and Children Mary Harney TD responded that John Curran, Minister of State with responsibility for co-ordinating the National Drugs Strategy, had identified headshops 'as an area of concern, and is currently considering the options available to more effectively control the activities of headshops'. www.oireachtas.ie

On 17 April 2009 the **Criminal Justice (Surveillance) Bill 2009** was introduced in Dáil Éireann. One purpose of the Bill is to buttress the work of the Garda Síochána, the Defence Forces and the Revenue Commissioners in the prevention and detection of serious crime. The Bill ensures that any legal obstacles to the admissibility in criminal trials of material obtained by means of secret surveillance are removed in cases involving arrestable offences. www.oireachtas.ie

Between 20 and 23 April 2009 the **International Harm Reduction Association (IHRA)** held its annual conference in Bangkok. The conference theme was 'harm reduction and human rights'. www.ihra.net

On 21 April 2009 the **Ana Liffey Drug Project's** 'Duck Dive & Survive' initiative won a prize in the Crystal Clear MSD Health Literacy Awards 2009. The initiative consists of two clearly-written leaflets promoting ALDP's peer support group and the outreach service. ALDP plans to use the €3,000 prize fund to establish a free text messaging service that will provide essential real-time information to service users. www.aldp.ie

On 30 April 2009 the **Central Statistics Office (CSO)** released **Recorded crime for quarter 1 (Q1) 2009**. The bulletin reported that the number of controlled drug offences increased by 5%, from 5,240 to 5,503, between Q1 of 2008 and Q1 of 2009. Possession of drugs for personal use offences rose from 3,893 to 4,286 over this period, an increase of 10.1%. www.cso.ie

(Compiled by Brigid Pike)

Recent publications

Journal articles

The following abstracts are cited from recently published articles relating to the drug situation in Ireland.

A profile of adolescent cocaine use in Northern Ireland

McCrystal P and Percy A
International Journal of Drug Policy 2009; 20(4): 357–364

The image of cocaine as a ‘party’ drug used by more affluent members of society has begun to change as the levels of use of the drug rise among school-aged young people. This study aimed to provide data on the prevalence estimates and associated behaviours of cocaine use among school attenders, a group that traditionally has received relatively little attention in the cocaine literature. Cocaine use patterns among young people aged 13–16 years who were participating in the Belfast Youth Development Study, a longitudinal study of adolescent drug use was explored. Data was collected through an annual data sweep in participating schools. This paper includes data collected in years 3, 4 and 5 of the study.

The results show higher levels of cocaine use among this age group than reported in much of the existing harm reduction literature. Lifetime use was 3.8% at age 13–14 years, rising to 7.5% at 15–16 years. The profile indicated that adolescent cocaine users were more likely to be female, live in disrupted families and experience social deprivation, which is similar to existing adolescent drug- user profiles. There was also some evidence of experimental cocaine use among the sample. These findings provide further evidence for the development of age-appropriate, school-focused harm reduction initiatives and continued monitoring of contemporary trends of use of cocaine among school-aged young people.

Cannabis reclassification: What is the message to the next generation of cannabis users?

McCrystal P and Winning K
Child Care in Practice 2009; 15(1): 57–73

At the beginning of 2004 the UK government downgraded the legal status of cannabis from a Class B to a Class C drug. Following a review of this decision two years later, cannabis remained a Class C substance –which for some contrasted with the potential harmful social and health effects associated with its use, particularly for young people. These included its links with respiratory damage, problems during pregnancy and its potential to exacerbate mental health problems. When Gordon Brown became Prime Minister in June 2007 his government decided to revisit this issue and requested a re-examination of its legal status. Despite the advice of its own scientific advisory body, the Advisory Council on the Misuse of Drugs, the UK government reclassified cannabis back to a Class B drug in May 2008.

This paper examines the existing scientific evidence on the potential impact of cannabis use on young people within the context of the UK government's reclassification initiative over the past four years. This evidence remains inconclusive whilst the perception of young people to the effects of cannabis use during, and now after, the period of the reclassification debate is not yet known. This now makes it particularly challenging to communicate a clear message in the most effective manner with young people about the possible risks of cannabis use, and would appear to make it difficult to provide a clear and unambiguous statement on what message this initiative has sent to the next generation of cannabis users, as they see the government rethink its position on several occasions before eventually changing its mind.

Alcohol misuse in the general hospital: some hard facts

Bradshaw P, Denny M and Cassidy E
Irish Journal of Medical Science 2008; 177(4): 339–342

Alcohol misuse is associated with considerable physical, psychological and social morbidity. The annual direct healthcare cost of alcohol-related problems in Ireland has been estimated to be 433 million Euro. There is also evidence that this population alcohol problem is reflected in attendances at and admissions to general hospitals. This study aimed to examine (1) the prevalence of alcohol use disorders in adult general hospital inpatients; (2) the accuracy of documentation in relation to alcohol use. A total of 210 random patients were interviewed out of 1,448 consecutive new admissions to Cork University Hospital over seven days. Case notes were reviewed for 206 (98%). Alcohol consumption was assessed using the Fast Alcohol Screening Test (FAST) and weekly drinking diary. FAST-positive (and a random sample of FAST-negative) patients then had a standardised interview. A total of 82% admitted for drinking alcohol. Among them, 22% were drinking in excess of guidelines, 9% had DSM-IV Alcohol Abuse and 7% dependence. The sensitivity and specificity of the FAST for detecting those drinking above guidelines were 89 and 94%, and for detecting a DSM-IV diagnosis was 100 and 73%. The majority of case notes contained inadequate information about alcohol intake. The authors conclude that alcohol use disorders are common and often undetected in the general hospital setting.

Chronic illness and multimorbidity among problem drug users: a comparative cross sectional pilot study in primary care

Cullen W, O'Brien S, O'Carroll A, O'Kelly FD and Bury G
BMC Family Practice 2009; 10(1): 25

Although multimorbidity has important implications for patient care in general practice, limited research has examined chronic illness and health service

Recent publications *(continued)*

utilisation among problem drug users. This study aimed to determine chronic illness prevalence and health service utilisation among problem drug users attending primary care for methadone treatment, to compare these rates with matched 'controls' and to develop and pilot test a valid study instrument. A cross-sectional study of patients attending three large urban general practices in Dublin, Ireland, for methadone treatment was conducted, and this sample was compared with a control group matched by practice, age, gender and General Medical Services (GMS) status.

Data were collected on 114 patients. Fifty-seven patients were on methadone treatment, of whom 52(91%) had at least one chronic illness (other than substance use) and 39(68%) were prescribed at least one regular medication. Frequent utilisation of primary care services and secondary care services in the previous six months was observed among patients on methadone treatment and controls, although the former had significantly higher chronic illness prevalence and primary care contact rates. The study instrument facilitated data collection that was feasible and with minimal inter-observer variation. The authors conclude that multimorbidity is common among problem drug users attending general practice for methadone treatment. Primary care may therefore have an important role in primary and secondary prevention of chronic illnesses among this population. This study offers a feasible study instrument for further work on this issue.

The development of a qualitative real-time RT-PCR assay for the detection of hepatitis C virus

Clancy A, Crowley B, Niesters H and Herra C
European Journal of Clinical Microbiology & Infectious Diseases 2008; 27(12): 1177–1182

Real-time polymerase chain reaction (PCR) represents a favourable option for the detection of hepatitis C virus (HCV). A real-time reverse transcriptase PCR (RT-PCR) assay was developed as a qualitative diagnostic screening method for the detection of HCV using the ABI PRISM® 7500 Sequence Detection System. The primers and probe were designed to target the 5'-untranslated region of the hepatitis C viral genome. A second heterologous probe assay was developed for the detection of the haemagglutinin gene of phocine distemper virus (PDV) and was used as an internal control. A semi-automated HCV extraction method was also implemented using the ABI PRISM™ 6100 Nucleic Acid PrepStation. The HCV assay was optimised as a qualitative singleplex RT-PCR assay with parallel testing of the target and internal control.

The assay results (n=200) were compared to the COBAS AMPLICOR™ HCV Test v2.0 assay. The assay demonstrated a high rate of sensitivity (99%), specificity (100%) and an acceptable limit of detection (LOD) of 100 IU/ml. The development of a qualitative multiplex assay for the simultaneous detection of HCV and internal control indicates the same high rates of sensitivity and specificity. This sensitive real-time assay may prove to be a valuable method for the detection of HCV.

(Compiled by Louise Farragher)

Upcoming events

(Compiled by Louise Farragher – lfarragher@hrb.ie)

October

7–9 October 2009

Models, implications and meanings of alcohol and drug treatment systems. A thematic meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol

Venue: Stockholm, Sweden

Organised by/Contact: NAD, Kettil Bruun Society

Tel: +44 (0) 20 7554 8533

Email: nads@nad.fi

www.nad.fi/index.php?lang=en

Information: The question of how best to allocate resources for treatment of alcohol and drug problems is increasingly important, not only in developing countries but also in affluent societies. The aim of this meeting is to develop and discuss new perspectives on alcohol and drug treatment systems, to encourage comparative research and to stimulate theoretical and methodological discussion among researchers from fields with

similar perspectives, such as mental health and care of the disabled. The meeting will strive to attract an international group of researchers, with support for researchers from low and middle income countries.

11–16 October 2009

Shaping the Future - A Multisectorial Challenge.
52nd International ICAA Conference on Dependencies

Venue: Estoril, Portugal

Organised by/Contact: International Council on Alcohol and Addictions

Tel: +44 (0)141 548 4507

Email: icaa2009@icaa.ch

www.icaa.ch/ICAA_Estoril_2009.html

Information: The conference will focus on identifying future trends in addiction prevention, treatment and policy and how practitioners should respond to these. The programme will include plenary sessions with keynote speakers of international renown addressing the conference's major themes.

Upcoming events *(continued)*

26–27 October 2009

National Conference on Injecting Drug Use (NCIDU)

Venue: Radisson Hotel, Glasgow

Organised by/Contact: Exchange Supplies

Email: www.exchangesupplies.org

Information: A packed and varied programme with over 30 parallel sessions, meetings, poster presentations and films to inform practice, disseminate research, explore policy and develop skills. If you would like to present a paper or workshop session on a subject relevant to the conference themes, please see full abstract submission details on our website, or call +44 (0)1305 262244.

November

11–14 November 2009

Reform 2009: The International Drug Policy Reform Conference

Venue: Albuquerque Convention Center, New Mexico, USA

Organised by/Contact: Stephanie Jones

Email: sjones@drugpolicy.org

www.drugpolicyevent.com

Information: This biennial conference brings together representatives from every corner of the drug policy reform movement – activists and students, drug users and those in recovery, harm reduction and treatment professionals, law enforcers and the formerly incarcerated – for three days of learning, debate and strategising. Topics covered will include: the latest developments in alternatives to incarceration,

harm reduction innovations, law enforcement and treatment, the history and future of psychoactive drugs, and drug policy reform locally, nationally and globally.

16–18 November 2009

11th International Hepatitis C Conference

Venue: Lowry Hotel, Manchester, UK

Organised by/Contact: Mainliners, 1 London Bridge, London SE1 4BG

Email: international09@mainliners.org.uk
www.hepc09.org.uk

Information: This conference will be a three-day event with a full programme of international speakers and oral abstract presentations. It is being organised by the Hepatitis C Resource Centre, a project of Mainliners, in partnership with the Greater Manchester Hepatitis C Strategy.

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The Alcohol and Drug Research Unit (ADRU) of the Health Research Board is a multi-disciplinary team of researchers and information specialists who provide objective, reliable and comparable information on the drug and alcohol situation, its consequences and responses in Ireland.

The ADRU maintains two national drug-related surveillance systems and is the national focal point for the European Monitoring Centre for Drugs and Drug Addiction. The unit also manages the National Documentation Centre on Drug Use.

The ADRU disseminates research findings, information and news through its quarterly newsletter, *Drugnet Ireland*, and the HRB series publications. Through its activities, the ADRU aims to inform policy and practice in relation to drug and alcohol use.